Certificate of CARE Assessment

This certificate is evidence of completion of a CARE assessment. Keep it with your medical records.

If you want to live in a nursing facility, you must take a copy of this certificate with you when you apply for admission. If you want to live in your home or other community-based setting, the Area Agency on Aging can help you find appropriate services.

This certificate is good for one year. If your health status or abilities change, you may request a new assessment. Should you need additional copies of this certificate or your completed two-page assessment, or want additional information, contact your Area Agency on Aging at: ______________________________

I certify that I have completed a CARE assessment for ______________________________
(client's name)

on ______________________. The preadmission requirement found in Public Law 100-203 has been met.
(date)

The Preadmission Screening and Annual Resident Review (PASARR) portion of the assessment:

___ did not indicate a need for further evaluation.

___ indicated a need for further evaluation. I am referring the client to a Level II assessor.

I am referring the client to a community-based service:

___ Area Agency on Aging ___ DCF Adult Services ___ Independent Living ___ Other ______________

No referral is necessary, the client:

___ does not need / does not wish help in finding community-based services.

___ has selected a nursing facility. ___ has not made final LTC decision.

______________________________ (Assessor Signature)

______________________________ (Assessor Number)

I hereby acknowledge that I have received a copy of the ***Notice of Right to Request a Fair Hearing*** attached to my copy of the Certificate of CARE Assessment.

______________________________ (Client's Signature)

______________________________ (Date)

Notice of Right to Request A Fair Hearing

If you do not agree with the determination of the PASARR column (Section II of the Level I CARE Assessment) referral regarding a Level II assessment as set forth on your CARE Certificate, you have the right to request a fair hearing to appeal this decision. This determination was made in accordance with the Health Care Financing Administration Rules and Regulations relating to Preadmission Screening and PASARR, 42 CFR Section 483.100 et. seq.

To request a fair hearing in accordance with K.A.R. 30-7-64 et. seq., **your request shall be in writing and delivered, or mailed to the following address so that it is received by the agency at the *Department of Administration Office of Administrative Hearings, 1020 S. Kansas, Topeka, KS 66612* within 30 days from the date on this Certificate of CARE Assessment.** (Pursuant to K.S.A. 77-531, an additional three days shall be allowed if you receive this certificate by mail.) Failure to timely request or pursue a fair hearing may adversely affect your rights.

At the hearing you will be given the opportunity to explain why you disagree with the agency action. You may represent yourself or be represented at the hearing by legal counsel, a friend, a relative, or other spokesperson.